DPHHS-SLTC -055
(Rev. 1/2014)

STATE OF MONTANA
Department of Public Health and Human Services

ENTRANCE/DISCHARGE INTO MEDICAID HOME AND COMMUNITY BASED SERVICES

APPLICANT:

Name: _____ Gender_____
(Last) (First) (MI)

Date of Birth: _____ Social Security Number: _____ Phone: _____

Address: _____

REFERRING AGENCY: Date to County: _____

Name: _____ Agency: _____

Address: _____ Phone:_____

ENROLLMENT REQUEST:

Notification to eligibility case manager. County Office of Public Assistance: _____

This is to notify you that the above-named individual has been enrolled in a Medicaid Home and Community Based Services (HCBS) Waiver Program. Please ensure that this recipient is listed in CHIMES as a waiver recipient with the waiver type listed below when Medicaid eligibility has been established.

ADMIT REQUEST:

Effective Date when HCBS is scheduled to start: _____

HCBS coverage dates must be entered into CHIMES on the Waiver web page.

HCBS Waiver:

- ☐ Aged Waiver
- ☐ Physically Disabled Waiver
- ☐ Severe Disabling Mental Illness Waiver
- ☐ DD0607 DD Children's Autism Waiver
- ☐ DD0208 Developmentally Disabled (DD) Comprehensive Services Waiver
- ☐ DD1037 DD Supports for Community Working and Living Waiver
- ☐ Other: _____

DISCHARGE REQUEST:

Effective Date when HCBS is terminated: _____

HCBS coverage dates must be entered into CHIMES on the Waiver web page.

TO BE COMPLETED BY COUNTY OFFICE: **CASE NUMBER:_____**

Notification to referral originator:

- ☐ Individual approved for Medicaid effective _____
- ☐ Waiver span has been entered into CHIMES, effective _____
- ☐ Individual denied Medicaid on _____
- ☐ No record of Medicaid application.

Incurment (spend down) amount _____

- ☐ Cash Option and/or medical expense.
- ☐ Using Home and Community Based Services for Aged and Physically Disabled.
- ☐ Other (explain) _____

Comments:_____

_____

Eligibility Case Manager: _____ Date: _____

Distribution: White-Referral Originator; Yellow-County; Pink-Originator (Suspense Copy)